FROM DETACHED CONCERN TO EMPATHY: HUMANIZING MEDICAL PRACTICE

"This book argues that by allowing patients to move them [emotionally], physicians gain access to a source of understanding illness and suffering that can make them more effective healers." By the beginning of the 21st century, this statement, which opens the preface of Halpern’s book, should be inarguable. Instead, it remains controversial. Virtually all medical students, when confronted by the very sick, are moved by their patients’ plight. They often feel so connected to their patients that they begin to have symptoms similar to theirs or experience painful loss at their deaths. These reactions to sadness, tragedy, and loss continue into the postgraduate years and beyond.

Seeking help for their distress, students and physicians-in-training are too often advised “not to get involved,” not to let their emotions or their attachment to patients carry them away. This useless idea, in one form or another, dates back a long time. It is uncommon for teachers to tell students exactly how to manage these emotions — where, after all, would they themselves have learned to do so? Consequently, physicians generally gravitate to one of three mechanisms. They may deny that the patient (or his or her family) is having the emotion to which the physician might otherwise react; they may feel the emotion and interiorize it, not letting anyone else know how bad they feel; or they may detach themselves from their own emotional reaction, acknowledging the patient’s difficulty but not their own response.

Halpern, a psychiatrist and philosopher, chooses to examine the third response and rejects the commonly offered arguments for its uselessness. "We can reject the arguments that attempt to justify detachment as an overall stance to prevent burn-out, permit effective technique, and promote impartiality," she writes. She wants instead to focus on "the most basic argument physicians give for maintaining detachment: emotions are inherently subjective influences that interfere with objectivity." Halpern is correct in stating that the history of medicine over the past almost 200 years has been occupied with a search for increasing scientific objectivity — a focus that has been intensified in recent decades by the success of medical science in understanding pathophysiology. The domain of the personal, where emotions have their effect, is irredually subjective. It is these subjective facts of the lives of patients that modify the presentation of diseases and their diagnosis and treatment. Failure to respond to the emotion that attends sickness leads to errors in diagnosis and treatment and to failure to understand and treat suffering. Unfortunately, it is impossible to banish emotions from medicine, because both physicians and patients are people, and emotions are as much a part of people as thought. Halpern points out that from the perspective of the objective domain of medicine, "emotions are seen as impinging on medical judgments in two distinct ways. First, certain emotional states are seen as disruptive to thinking. For example, if a physician became very angry he might have trouble concentrating. Second, and more fundamentally, even calm emotions are seen as unreliable sources of information."

A large portion of the book is given over to alternative views of the problems posed to thought by the emotions. In ancient Greece, the emotions or “passions” were seen as opposed to reason. Reason, in this view, is a mental faculty distinguished from the emotions, sensation, and will. Philosophers continue to argue about what reason actually is or does. In dealing with everyday life, we are better off considering thought and how it acts in bringing together information and forming it into propositions — statements that can be assembled in logical steps toward a judgment or a conclusion. It makes no difference to logical thought what material it has to work on; it does equally well with the factual, the mystical, the irrational, and the biochemical. So when Halpern explains repeatedly that emotions are irrational — a common view dating back to Plato — it is not very useful. What are we to think about (or with) the emotions that Halpern wants us to attend to if they have no logical basis — especially given the fact that all meanings, the concepts we use to interpret the world, objects, events, relationships, people, and circumstances, include emotions along with their cognitive content?

There is increasing evidence to suggest that emotions are evaluative in nature (see, for example, Martha Nussbaum’s recent encyclopedic Upheavals of Thought [Cambridge, United Kingdom: Cambridge University Press, 2001]). Far from "irrational," they are a kind of facts generated by reactions to the world — a perfectly reasonable substrate for thought. The cognitive response “I have cancer” for example, plus the emotional response of dread, register what a thing is and our evaluation of it. For those taking care of patients, knowledge of not only the brute facts that they relate about their illness but also the emotions that those facts generate within them gives insight into where patients stand in relation to the illness. The emotions that patients arouse within physicians are also evaluative and tell physicians much about the patients, about themselves, and about their relationship.

The best chapter in the book discusses the concept, meanings, uses, and achievement of clinical empathy. Halpern’s review of various ways of understanding empathy is very useful. Rejecting the models of affective merging (which is common among psychoanalysts) and detached insight, she develops her own theory that empathy is emotional reasoning. According to this view, the “empathizer is able to resonate emotionally with, yet stay aware of, what is distinct about the patient’s experience." This model requires one to have the ability to imagine how it feels to experience something.

Experience suggests, however, that no one model of empathy is sufficient. What is needed is the desire to share the patient’s experience or emotion; if that desire is present, whatever tools one has at hand — affective merging, insight from past experience, extremely close attention to the patient, imaginative participation in the patient’s experience, anything that seems helpful — will do the job. At the same time, the physician must always remember, as a protection against the sometimes threatening closeness of empathy, that he or she is a physician working. Even when physicians are at their most empathetic, it is not the same as being among
family members or close friends: they are still being physicians. This chapter is worth reading.

Overall, this is an important book. I recommend it to physicians and members of medical faculties for whom its subject matter is important. It is a serious essay on subjectivity, a topic about which we will be seeing more in the coming years. It repays the work of reading it.

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STORIES MATTER: THE ROLE OF NARRATIVE IN MEDICAL ETHICS
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YOU will search medical textbooks in vain for the differential diagnosis distinguishing modern illness from postmodern illness. But if this dichotomy and the evolution of the former into the latter were established, the project of narrative ethics would follow logically. According to David Morris, a contributor to Stories Matter, the modern perspective is “biomedical”: we are our genes, our organs, our laboratory measurements. The postmodern perspective is “biocultural”: we are made of stories — cultural, familial, interpersonal, psychological, emotional, and biological narratives. “Reading” these stories from the perspective of the main characters is the job of physicians and medical ethicists.

The notion that we are narratively constructed (related to the belief that reality consists of many local truths rather than one universal Truth) is called “constructionism”; it contrasts with “essentialism,” the belief in a deep, permanent self. But it is unclear what ethics would entail in a world populated by constructs — or why any construct would concern itself with ethical behavior toward another construct. Thus, narrative ethicists embrace a modified postmodernism, in which narratives do not constitute persons but rather provide the best access to them. Although, as Charon notes, “the self cannot be created — or even found — independent of narrative activities,” there is, according to various contributors, an “authentic” or “true” self. Despite the different perspectives of physicians and patients, they are “of the same substance at the deepest levels of human experience and value.” Physicians must connect with patients at that level and flush out their stories — preferably escaping the realm of the “objective” professional to enter those stories as interactive, three-dimensional characters (not archetypal heroes) — in order to make ethical decisions about patients’ care.

This requirement demands an involved process: one cannot simply hear a traditional case presentation, apply abstract principles (most famously, autonomy, beneficence, nonmaleficence, and justice), and rest assured of ethical rectitude. Many pertinent persons must have a voice, including those usually marginalized, for narrative ethics is allegedly democratic where “principlist” ethics is elitist. Unlike “principlism,” which sees the world in black and white, narrative ethics purports to accommodate real-life grays and therefore to be more humane.

This revolution in medical ethics is part of a larger transformation in the sciences — the “narrative turn,” based on the belief that much human knowledge takes narrative form. A corollary is that methods used by literary scholars in interpreting fictional narratives are valuable for those reading life stories. So for 30 years, literature has been infiltrating medical school curriculums, and for about 20 years, ethicists have drawn on methods of literary interpretation.

Many of the contributors to Stories Matter are major players in this narrative movement. Here, they practice what they preach, building their essays on stories of patients who want to conceal their medical conditions from their families, 60-year-old women who want to use assisted reproductive technology, parents of infants born with neurologic injuries who want to let them die — stories on whose proper endings reasonable people might disagree. The authors do agree on certain concepts — the emphasis on particulars, multiple perspectives, context, and emotional as well as rational understanding. Many stress the obligation incurred by hearing a story of suffering.

But because the narrative approach comprises an evolving variety of practices rather than a unified theory, these authors do not establish new rules. As a result, there is inevitably a fair amount of variation in the procedures followed, the elements of literary narrative that are deemed central (character development, plot, symbolism, closure, and voice, among others), the tools of literary interpretation that are considered useful, and the applications considered appropriate in the medical domain (deliberations of ethics committees, but also daily relations between doctors and patients and the obtaining of informed consent from study participants).

Such variation is generally promising, but in some instances, dispersion highlights the theoretical danger of stretching the concept of “narrative” to the point of meaninglessness. Despite intriguing questions raised by a chapter on consent forms, for instance, I wonder whether such forms can really be considered narratives. Moreover, at times, the divergence seems similar to the conflicting perspectives valorized by the narrative approach, which hints at a practical danger: a narrative-ethical deliberation might, as it embraces ambiguity and open-endedness, “undermin[ing] the false confidence that an ethical dilemma necessarily calls for or accommodates a single right action,” prove to be interminable. When all the evolving stories have been told and heard, what then? How does one proceed in an environment in which there is no accessible objective truth and no rules? In this sense, narrative ethics might work better as an approach to ongoing relationships than for momentous decisions in which only one path may be chosen.

Some of the contributors to this book simply delineate conflicting perspectives on a given case and leave the matter unresolved — perhaps implying that the best course of action will become evident once the physician is transformed from detached “author” to engaged “character.” Others finally return to principles, suggesting that decisions must be made on the basis of rules but will be better informed after the narrative process. Contributor Howard Brody voices the hope that principlism will turn out to have “irredubitably nar-